Mercer Administration, A Service of Seabury & Smith, Inc. co. # _____ ee. # _____

A. Application Type

☐ New Hire ☐ Late Enrollee ☐ Special Enrollee (indicate event & date below) ☐ Change (indicate event & date below) ☐ Open Enrollment

Event Requiring Contract Change: ☐ Marriage ☐ Death ☐ Divorce ☐ Birth/Adoption ☐ Other_____ Event Date _____

SSN	Name (Last)	(First)	(MI)
Birth Date	Address (Street)		(Apt/Ste #)
Gender ☐ Male ☐ Female / Marital Status ☐ Single ☐ Married ☐ Common Law	(City)	(State) (Zip)	(Phone Number)

Medicare Enrolled? ☐ Yes ☐ No | Soc. Sec. Disabled? ☐ Yes ☐ No | Medicare ID (HIC) No. ☐ Part A ☐ Part B ☐ Part D Eff. Date:

B. Coverage Election – Please indicate the coverage you are choosing

Medical (if applicable): ☐ Self ☐ Spouse ☐ Child(ren) Plan Type_____
Dental (if applicable): ☐ Self ☐ Spouse ☐ Child(ren) Plan Type_____
Vision (if applicable): ☐ Self ☐ Spouse ☐ Child(ren) Plan Type_____

☐ Life ☐ AD & D ☐ STD ☐ LTD

C. Employer – Please complete shaded section for applicant

Company Name		Applicant Occupation	
Company Location	Class	Employer Signature	Date
Hire Date / Eff. Date	Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA	Salary $ ☐ Monthly ☐ Annually	
	Please indicate plan if multiple plans are available: ☐ Health _____ ☐ Dental _____ ☐ Vision _____		

☐ Employee Life	☐ Employee AD&D	☐ Employee Opt. Life	☐ Dependent Life	☐ Spouse Opt. Life	☐ Employee STD	☐ Employee LTD
$	$	$	$	$	$	$

D. Beneficiary Information

	Birth Date	SSN	Relationship	%
Primary Beneficiary				
Contingent Beneficiary				

E. Dependents Enrolled (First, MI, Last)

	Birth Date	Social Security Number	Gender	Full-Time Student?	Soc. Sec. Disabled?	Medicare Enrolled?
Spouse			☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Dependent			☐ M ☐ F	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

F. Other Coverage Information

If you, your spouse or anyone named on this application will keep other hospital and/or medical coverage in addition to this coverage, please complete the

Name (First, MI, Last)
Employer (if applicable)
Insurance Company/ HMO Name and Address
Policy No. | Contract Type: ☐ Single -Medical ☐ Family -Medical ☐ 2 person-Medical | Eff. Date:

G. Prior Coverage Information

– Did you have health insurance in the last 63 days? If yes, please complete the following section:

Name of Covered Person
Employer (if applicable)
Insurance Company/ HMO Name and Address
Policy No. | Contract Type: ☐ Single -Medical ☐ Family -Medical ☐ 2 person-Medical | Eff. Date: End Date:

H. Employee Waiver of Coverage

I, the undersigned, hereby certify that I have been given an opportunity to enroll in the group plan sponsored by my employer. After careful consideration, I have elected not to participate in the following coverage(s). I further understand that should I decide to participate at a future date, I may have to furnish satisfactory evidence of insurability for myself and, if applicable, any eligible dependents. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I understand that I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after my other coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

- ☐ Employee Health
- ☐ Employee Dental
- ☐ Employee Vision
- ☐ Employee Life
- ☐ Employee AD&D
- ☐ Employee Weekly Indemnity (STD)
- ☐ Employee Long Term Disability (LTD)
- ☐ Employee Optional Life
- ☐ Spouse Optional Life
- ☐ Dependent Health
- ☐ Dependent Dental
- ☐ Dependent Vision
- ☐ Dependent Life
- ☐ Other _____

Employee Signature_____
Date_____
Witness Signature _____
Date_____

I. Employee Signature (Required for all available lines of coverage)

I HEREBY REQUEST to be covered and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the coverage elected on this form. I hereby represent that any disability indemnity coverage in force and applied for, with respect to myself, is less than 100% of my annual earnings and I further represent that I am not presently disabled and I am performing all the duties of my occupation. (This statement applies to any disability coverage).

Signature_____ Date_____